

Registered pharmacy inspection report

Pharmacy Name: Gordons Chemists, 52a Sinclair Street,
HELENSBURGH, Dumbartonshire, G84 8TQ

Pharmacy reference: 1041986

Type of pharmacy: Community

Date of inspection: 26/08/2020

Pharmacy context

During the Covid-19 pandemic the pharmacy is mainly dispensing NHS prescriptions and delivering medicines to people at home. It supplies some medicines in multi-compartment compliance packs, provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use and supplies a range of over-the-counter medicines.

Overall inspection outcome

✓ **Standards met**

Required Action: None

Follow this link to [find out what the inspections possible outcomes mean](#)

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy updates its working instructions to keep its processes and procedures safe and effective. Pharmacy team members sign the instructions to show they follow safe systems of work. They record and discuss their dispensing mistakes and review the information to learn and manage risks. The pharmacy protects people's personal information and prevents sensitive information being seen by people who are not authorised to do so. The team members know the importance of their role in protecting vulnerable people. They also keep legal records up to date.

Inspector's evidence

The company had been issuing regular safety updates since the start of the Covid-19 pandemic. The updates supported the team members to introduce new working practices. An area manager had been providing the team members with support to keep them safe. This included confirming they had been wearing appropriate face masks as personal protective equipment (PPE). And observing social distancing as far as possible while working in the dispensary. A Perspex screen at the medicines counter created a barrier between the team members and people that visited the pharmacy. And the number of people in the waiting room at the one time had been restricted to two. The team members had placed markings on the floor to show people where to stand to keep two metres apart. And notices instructed people to avoid browsing the retail area to keep the queue moving. Posters in the window provided public health information about the transmission of the virus and how to protect against it. This included social distancing and the wearing of masks. Hand sanitiser was available at the entrance to the pharmacy and at various locations in the dispensary. The team members used it on a regular basis. The pharmacy continued to close between 1.00 and 2pm for team members to clean the premises during the day.

The company had recently reviewed and updated its working instructions and the team members had read and signed them. This ensured their learning was up to date, and services were safe and effective. The 'accuracy checking technician' (ACT) procedure had been recently updated and implemented. The ACT had not been checking since the start of the pandemic. This was due to an increase in the number of pharmacists working in the pharmacy. Since the last inspection, the pharmacy had introduced a stamp for prescriptions. And the ACT and the pharmacists knew to sign the boxes on the stamp to show who had performed the necessary clinical check and the final accuracy check. The pharmacy displayed the responsible pharmacist notice. It showed the name and registration number of the pharmacist in charge. The pharmacist in charge kept the responsible pharmacist record up to date.

The pharmacy team members signed dispensing labels to show they had completed a dispensing task. This helped the pharmacist and the accuracy checking technician (ACT) support individual team members improve their accuracy and manage risks. It also acted as an audit trail of who had been involved in the dispensing process. The team members had been keeping near miss errors, but they had been unable to sustain this during the Covid-19 pandemic due to the extra workload and workplace pressure this created. They had an awareness of risks and had separated products to manage selection errors. For example, levothyroxine/losartan and amitriptyline/amlodipine had been moved. The pharmacy had re-introduced near miss errors recording at the start of August 2020, when the workload had fallen. But the level of recording had not been enough to inform them about the need for

improvements. The pharmacist managed the incident reporting process, and they used the company's on-line report form to document the root cause and the improvement action taken. The pharmacy had introduced a complaints leaflet since the last inspection, and it was being displayed at the medicines counter. The team members knew to handle complaints in a sensitive manner, and they referred dispensing incidents to the pharmacist for them to investigate.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place, and they were valid until 30 September 2020. The team members recorded private prescriptions and records met legal requirements. Specials records were kept up to date with details of each person who had received a supply. The company trained its team members to protect confidential information, and it displayed information about its data protection arrangements. This provided people with the assurance that their information was safe and secure. The pharmacy had purchased a new shredder since the last inspection, and the team members knew to use it to safely dispose of confidential information. The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The company did not formally train its team members to identify vulnerable adults and children. But they knew to refer concerns to the pharmacist so they could take the necessary actions to protect people.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team members are qualified for their roles and the services they provide. The pharmacy supports trainees to develop their skills. It also provides them with protected learning time in the workplace to complete training courses. The pharmacy updates the team members about changes to pharmacy services when they arise. But it doesn't provide training so that team members continue to develop in their roles after they qualify. The team members support each other in their day-to-day work. They are enthusiastic and knowledgeable in their roles, and they suggest improvements to make services more effective.

Inspector's evidence

The pharmacy's workload and footfall had reduced slightly over the past six months. The pharmacy team had remained mostly the same, and a provisionally registered pharmacist had been appointed. The pharmacist in charge had worked at the pharmacy for around 12 years. And the provisionally registered pharmacist had completed their pre-registration training year there. The pharmacist and the area pharmacist manager had carried out a formal risk assessment to provide assurance the provisionally registered pharmacist met the necessary standards to practise as a pharmacist. There had also been a follow-up risk assessment to provide ongoing assurance. The team members were supporting the provisionally registered pharmacist to develop and this was to continue until they started working as a relief pharmacist across the other branches. The pharmacist manager was recruiting to replace a dispenser that had left their post, and the other team members were covering and until the vacant post was filled. Following the last inspection, the pharmacist had enrolled the counter assistants on the medicines counter assistants training course. All but one team member had completed the course and they were qualified to work on the medicines counter.

The pharmacy kept copies of qualifications and training certificates on-site. This provided evidence of accreditation should it be needed. The following team members were in post; one full-time pharmacist, one second part-time pharmacist, one full-time accuracy checking technician (ACT), one full-time trainee pharmacy technician, one full-time medicines counter assistant, four part-time medicines counter assistants and one trainee medicines counter assistant. The pharmacist usually carried out individual performance reviews once a year. But the reviews were delayed due to the Covid-19 pandemic. The pharmacist supported trainees to learn and develop. They allocated protected learning time for them each week depending on the workload. The trainee pharmacy technician had been supported by the pharmacy team to complete workplace activities during the working day.

The pharmacy team had been focussed on learning about the new arrangements that were needed to manage the risk of virus transmission. They had also learned about the new 'NHS Pharmacy First' service that launched at the end of July 2020. The company usually used numerical targets to grow the services it provided. The pharmacy's activity had fallen slightly at the start of the Covid-19 pandemic. But there was no pressure on the pharmacy to try to deliver the service levels it had before the start of the pandemic. The team members were currently promoting the 'NHS Pharmacy First' service. They knew this was for the benefit of vulnerable people and people who needed treatment for minor

ailments. The pharmacy team members felt empowered to raise concerns and to provide suggestions for improvement. The pharmacy technician had introduced initiatives to improve the dispensing process. For example, they designed a document holder so that prescriptions were easier to read, and a stand for a de-blistering machine so that team members could remain standing when carrying out the process.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and hygienic and has infection control arrangements in place. It has consultation facilities to meet the needs of the services it provides, and people can speak in private.

Inspector's evidence

The consultation booth was out of use due to the pandemic. The pharmacist described the pharmacy's new arrangements to people when they wanted to speak to them in private. Some people agreed to speak to the pharmacist when they were the only person in the waiting area at the time. Others preferred to return home or to their cars and speak on the pharmacist on the phone. This ensured people's privacy and dignity was respected and protected.

The pharmacy team members had re-arranged the dispensary since the last inspection. They had cleared a rear dispensing bench and moved one of the computers into a corner. This had reduced the amount of congestion on the benches and had created another workstation for the team members to work from. They were unable to maintain a two-metre distance from each other. But they tried to work in separate areas as much as possible.

The pharmacists supervised the medicines counter from the checking bench. This meant they could make interventions when necessary. The pharmacy had effective lighting, and the ambient temperature provided a suitable environment from which to provide services. Pharmacy team members completed all cleaning tasks. A new cleaning rota ensured that work surfaces and public areas were cleaned more frequently.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy displays service information in the window and keeps people up to date with changes. It provides public health information and safety information to help protect people from Covid-19. The pharmacy mostly stores and manages its medicines appropriately. And the team members act on safety notices and remove faulty medicines from use. They know the importance of making additional checks with people about their high-risk medicines. And when to speak with them about their medicines to help keep them safe. The pharmacy has working instructions for the team members to follow which support them to deliver services in a safe and effective way.

Inspector's evidence

The pharmacy had step free access and it provided unrestricted access for people with mobility difficulties. It displayed information in the window about the services it provided, and it promoted public health information to help protect people from the coronavirus. The team members kept healthcare information leaflets stocked-up. These were available for self-selection from a stand at the side of the medicines counter. Topics included information about the new 'NHS Pharmacy First Service' and how to make a complaint about the pharmacy service. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. They were familiar with the PGDs they used on a regular basis and did not keep hard copies of them in the pharmacy. NHS Highland kept PGDs on its website, and the pharmacists referred to them when they needed to check for information.

The pharmacy provided a delivery service and the driver always kept a safe two metres distance away from people. They placed items at the person's door until they were taken inside, and they kept an audit trail of deliveries that had been completed. The pharmacy team members knew about 'high-risk' medicines. They knew to look for extra information attached to prescriptions bags and to act accordingly. The pharmacy technician had produced warning leaflets to attach to prescription bags when needed. The team members attached the warning leaflets to ensure they carried out extra tasks. For example, one of the leaflets instructed them to add fridge items, and another to call on the pharmacist to counsel people. The team members knew about the valproate pregnancy protection programme, and they knew where to find the safety leaflets and cards and when to issue them to people. The pharmacy team members used dispensing baskets. They used these to keep prescriptions and medicines safely contained throughout the dispensing process.

Multi-compartment compliance pack dispensing was provided for around 160 people. This had increased by around 10% over the last six months. The team members had made changes to the dispensing procedure since the last inspection. And they now dispensed packs on a four-week cycle. This made it easier for them to manage the workload and dispense packs in advance of them being needed. They also used supplementary records to keep track of when packs were due. These were kept in four folders that corresponded to each week of the cycle. The team members updated the records following prescription changes. This kept a robust audit trail of changes should it be needed. The team members did not always provide descriptions of medicines on the labels. This could make it harder for the person or their carer to identify the medicines inside. They did not always supply patient information with the packs. This could mean that people don't have all the information they need to help them take their medicines safely. Refurbishment and extension of the main dispensary had been

delayed due to Covid-19. And the dispensing of packs took place in a separate part of the registered premises. This was due to the limited available space in the main dispensary. The area was accessed via a separate door a few blocks along the street. The pharmacist carried out regular checks and the team members ensured they kept the door locked and the room secured at all times.

The pharmacy purchased medicines and medical devices from recognised suppliers. The team members carried out regular stock management activities and highlighted short-dated stock and split packs during regular checks. They used 'red dot' stickers to highlight short-dated stock. The medicines fridge had an integrated thermometer for the team members to carry out temperature checks. On the day of the inspection the fridge temperature was within the safe range between 2 and 8 degrees Celsius and the boxes were cold. But, on checking the records the fridge temperature had not been recorded since 22 August 2020. The team members could not confirm the temperature had remained with 2 and 8 degrees since records stopped. The team members acted on drug alerts and recalls. They recorded the date they checked for affected stock and what the outcome had been. For example, they had checked for digoxin tablets in August 2020 with no affected stock found. The team members knew about the Falsified Medicines Directive (FMD). But the company had not provided the necessary resources to implement the system.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. It keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment, and the measure for methadone was highlighted, so it was used exclusively for this purpose.

The pharmacy kept cleaning materials for hard surface and equipment cleaning. Members of the team kept the pharmacy sink clean and suitable for dispensing purposes. They kept computer screens out of sight of people in the waiting area and used a portable phone to keep personal conversations private. The team members wore face masks throughout the day, and they washed and sanitised their hands on a regular basis.

What do the summary findings for each principle mean?

Finding	Meaning
✓ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✓ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✓ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.